U.S. Department of Labor

Office of Administrative Law Judges
36 E. 7th Street, Suite 2525
Cincinnati, Ohio 45202

(513) 684-3252
(513) 684-6108 (FAX)

Issue Date: 11 April 2003

Case No: 2000-BLA-0309

In the Matter of

MILDRED M. KIRBY, Widow of
ROBERT A. KIRBY, Deceased

Claimant

v.

OLD BEN COAL COMPANY

Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS

Party-in-Interest

APPEARANCES:

Thomas E. Johnson, Esq.
JOHNSON, JONES, SNELLING, GILBERT & DAVIS
Chicago, Illinois
For Claimant

Richard H. Risse, Esq.
WHITE & RISSE
St. Louis, Missouri
For the Employer/Carrier

BEFORE: RUDOLF L. JANSEN
Administrative Law Judge

DECISION AND ORDER — AWARDING BENEFITS

This proceeding arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended. 30 U.S.C. § 901 *et seq.* Under the Act, benefits are awarded to coal miners who are totally disabled due to pneumoconiosis. Surviving dependents of coal miners whose deaths were caused by pneumoconiosis also may recover benefits. Pneumoconiosis, commonly known as black lung, is defined in the Act as "a chronic dust disease of the lung and its sequelae, including pulmonary and respiratory impairments, arising out of coal mine employment." 30 U.S.C. § 902(b).

On December 30, 1999, this case was referred to the Office of Administrative Law Judges for a formal hearing. The hearing was held on August 27, 2002 in Evansville, Indiana. The findings of fact and conclusions of law that follow are based upon my analysis of the entire record, arguments of the parties, and applicable regulations, statutes, and case law. They also are based upon my observation of the appearance and demeanor of the witness who testified at the hearing. Although perhaps not specifically mentioned in this decision, each exhibit received into evidence has been reviewed carefully, particularly those related to the miner's medical condition. The Act's implementing regulations are located in Title 20 of the Code of Federal Regulations, and section numbers cited in this decision exclusively pertain to that title. References to "DX," "EX," and "CX" refer to the exhibits of the Director, Employer, and Claimant, respectively. The transcript of the hearing is cited as "Tr." and by page number.

ISSUES

The following issues remain for resolution:

1. Whether issue preclusion bars Employer from litigating the presence of pneumoconiosis by the finding of pneumoconiosis in the Decision and Order of Mr. Kirby's living miner claim

2. Whether the miner had pneumoconiosis as defined by the Act and regulations;

3. Whether the miner's pneumoconiosis arose out of coal mine employment;

4. Whether the miner's death was due to pneumoconiosis; and

5. Whether, in the event of the death of Mrs. Kirby prior to final adjudication of her claim, Employer would be liable for payment of benefits to any survivor of Mrs. Kirby or to her estate, heirs, executor administrator or his or her assigns.

The Employer also contests other issues relating to the constitutionality of the Act and regulations. (DX 13). These issues are beyond the authority of an administrative law judge and are preserved for appeal purposes only.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and Procedural History

Robert A. Kirby, Claimant's husband and the miner upon whom this claim is based, was born on June 22, 1928 and died on March 28, 1999. Claimant and the miner were married on May 1, 1967, and they resided together until the miner's death. They had no children who were under eighteen or dependent upon them at the time this claim was filed. At the time of the hearing, Claimant resided in Winslow, Indiana and had not remarried. (DX 2,3).

Mr. Kirby became dyspneic upon exertion, which led to his retirement from coal mining in 1992. He suffered from repeated respiratory infections and a productive cough. The record reveals various accounts of Mr. Kirby's smoking history. The record contains evidence that Mr. Kirby began smoking cigarettes between the ages of seven and ten. Ms. Kirby testified and Mr. Kirby reported to physicians that he quit smoking in 1987 or 1988.

Several of the physicians of record have noted that an arterial blood gas study shows a higher than normal level of carbon monoxide in Mr. Kirby's blood. Dr. Gregory J. Fino stated that this elevated carbon monoxide level is indicative of continued smoking. However, Dr. Fino also stated that other environmental factors can cause such an elevation. (EX 7 at 20-21). Although there is one account in which a physician records Mr. Kirby as smoking four packages of cigarettes per day, Mrs. Kirby testified that throughout their marriage Mr. Kirby never smoked four packages of cigarettes a day. The majority of the reports of smoking history state that Mr. Kirby smoked two packages of cigarettes a day. The physicians of record are consistent in crediting Mr. Kirby with a smoking history of two packages of cigarettes per day for fifty years or one hundred pack years. I find that the

evidence supports a finding of a smoking history of two packages of cigarettes a day for fifty years.

Claimant, Mildred M. Kirby, timely filed her application for survivor's benefits under the Act on April 23, 1999. The Office of Worker's Compensation Programs denied the claim on October 25, 1999, and, after reviewing additional evidence, affirmed its denial on November 29, 1999. Pursuant to Claimant's request for a formal hearing, the case was transferred to the Office of Administrative Law Judges on December 30, 1999. (DX 20, 24).

Coal Mine Employment

The duration of a miner's coal mine employment is relevant to the applicability of various statutory and regulatory presumptions. At the hearing, the parties stipulated that Claimant worked at least twenty years in qualifying coal mine work. Based upon my review of the record, I accept the stipulation as accurate and credit Claimant with twenty years of coal mine employment.

Mr. Kirby worked the first two years of his coal mine employment underground as a jerryman. The remainder of his coal mine employment took place aboveground where he worked as a staggerman, bull gang repairman, tipple repairman, driller helper, coal truck driver, and utility man. Each of these positions involved significant coal dust exposure.

MEDICAL EVIDENCE[1]

X-ray reports

Exhibit	Date of X-ray	Date of Reading	Physician/ Qualifications	Interpretation
EX 9	03/27/99	05/04/02	Repsher/B	Negative for pneumoconiosis
EX 8	03/27/99	03/21/02	Dahhan/B	Negative for pneumoconiosis
EX 5	03/27/99	09/25/00	Fino/B	Negative for pneumoconiosis
EX 4	03/27/99	09/12/00	Renn/B	Unreadable X-ray

[1] Many of the physicians of record include in their independent medical reviews the assessment of x-ray interpretations, pulmonary function studies and arterial blood gas studies that are not a part of the current record. As those interpretations and studies are not in the record, I do not include them here.

Exhibit	Date of X-ray	Date of Reading	Physician/ Qualifications	Interpretation
EX 2	03/27/99	12/28/99	Meyer/B, BCR	Unreadable X-ray
EX 1	03/27/99	12/13/99	Shipley/B, BCR	Negative for pneumoconiosis
DX 21	03/27/99	12/10/99	Spitz/B, BCR	Negative for pneumoconiosis
DX 21	03/27/99	11/18/99	Wiot/B, BCR	Negative for pneumoconiosis
EX 1	03/27/99	11/16/99	Perme/B, BCR	Negative for pneumoconiosis
DX 14	03/27/99	03/27/99	Moss/unknown	Not assessed for pneumoconiosis
EX 9	07/11/97	05/11/02	Repsher/B	Negative for pneumoconiosis
EX 8	07/11/97	03/21/02	Dahhan/B	1/0
EX 5	07/11/97	09/25/00	Fino/B	Negative for pneumoconiosis
EX 4	07/11/97	09/12/00	Renn/B	Negative for pneumoconiosis
EX 2	07/11/97	12/28/99	Meyer/B, BCR	Negative for pneumoconiosis
EX 1	07/11/97	12/13/99	Shipley/B, BCR	Negative for pneumoconiosis
DX 21	07/11/97	12/10/99	Spitz/B, BCR	Negative for pneumoconiosis
DX 21	07/11/97	11/18/99	Wiot/B, BCR	Negative for pneumoconiosis
EX 1	07/11/97	11/16/99	Perme/B, BCR	Negative for pneumoconiosis
DX 14	07/11/97	07/11/97	Powers/unknown	Not assessed for pneumoconiosis
DX 14	07/09/97	07/09/97	Powers/unknown	Not assessed for pneumoconiosis
DX 14	04/10/96	04/10/96	Ross/unknown	Not assessed for pneumoconiosis
EX 8	12/20/92	05/04/02	Repsher/B	Negative for pneumoconiosis
EX 9	12/20/92	03/21/02	Dahhan/B	1/0
EX 5	12/20/92	09/25/00	Fino/B	Negative for pneumoconiosis
EX 4	12/20/92	09/12/00	Renn/B	Negative for pneumoconiosis
EX 2	12/20/92	12/13/99	Shipley/B, BCR	Negative for pneumoconiosis
DX 21	12/20/92	12/10/99	Spitz/B, BCR	Negative for pneumoconiosis
EX 1	12/20/92	11/16/99	Perme/B, BCR	Negative for pneumoconiosis

"B" denotes a "B" reader and "BCR" denotes a board-certified radiologist. A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successfully completing an examination conducted by or on behalf of the Department of Health and Human Services (HHS). A board-certified radiologist is a physician who is certified in radiology or diagnostic roentgenology by the American Board of Radiology or the American Osteopathic Association. *See* 20 C.F.R. § 718.202(a)(ii)(C).

Arterial Blood Gas Studies

Exhibit	Date	Physician	pCO_2	pO_2	Resting/ Exercise
DX 14	03/15/99	Gehlhausen	47	43	Resting
DX 14	03/27/99	Gehlhausen	53	57	Resting

Narrative Medical Evidence

The record contains medical records from three visits Mr. Kirby made to Dr. Daniel Combs for treatment on February 20, 1997, April 7, 1997 and May 21, 1997. (DX 9). These records refer to diagnoses of chronic obstructive pulmonary disease (COPD), bronchitis, asthma, and coal workers' pneumoconiosis. In addition, the records detail the medications prescribed to Mr. Kirby for these conditions. Dr. Combs' qualifications are not of record.

The record also contains hospital records from 1996 until 1999 from Wirth Regional Hospital in Oakland City, Indiana. (DX 15). Terry C. Gehlhausen, D.O., was the treating physician in each of Mr. Kirby's admissions to the hospital. On April 9, 1996, Mr. Kirby was admitted to the hospital upon complaints of acute urinary incontinence and fever. Upon discharge, Dr. Gehlhausen diagnosed Mr. Kirby with pneumonia and COPD in addition to urinary incontinence. On July 9, 1997, Mr. Kirby was admitted to the hospital due to breathing problems. Dr. Gehlhausen diagnosed Mr. Kirby with pneumonia, COPD and pneumoconiosis. Dr. Gehlhausen noted that Mr. Kirby did not smoke. Mr. Kirby was admitted to the hospital on March 15, 1999 for pulmonary insufficiency. Dr. Gehlhausen noted that Mr. Kirby was "so dyspneic that he can hardly do anything but gasp for air." Mr. Kirby was discharged on March 18, 1999; however, he was readmitted on March 27, 1999. He was diagnosed with bacterial pneumonia, hypovolemia, septicemia,

pneumoconiosis, and strep. Mr. Kirby died at the hospital on March 28, 1999. Dr. Gehlhausen's credentials are not of record.

John A. Heidingsfelder, M.D., performed an autopsy on March 28, 1999. (DX 7). In the Preliminary Autopsy Report, Dr. Heidingsfelder opined that Mr. Kirby suffered from the following conditions: (1) Marked pulmonary anthracosis and lymph nodal anthracosis; (2) Marked, bilateral bullous emphysema with mild pitting and trenching of mainstream bronchi; (3) Extensive anthracotic pigment deposition throughout the lungs; (4) Focal pleural fibrosis in the left upper lobe of the lung; (5) Pneumonia; (6) Coal workers' pneumoconiosis; and (7) Severe atherosclerosis in the proximate right coronary artery.

In a microscopic examination, Dr. Heidingsfelder reiterated the above diagnoses and reported additional findings from microscopic analysis of slides gathered from the autopsy. (DX 21). Dr. Heidingsfelder found anthracotic macules and anthracotic-fibrotic macules measuring one to three millimeters in dimension. He noted marked pulmonary anthracosis and pleural, subpleural and interstitial pulmonary fibrosis. He reported that the lymph nodes showed marked anthracosis with focal nodule formation and a focal well-differentiated adenocarcinoma. He also diagnosed pulmonary emphysema with bullous lesions and pneumonia.

Dr. Heidingsfelder also submitted a medical report on August 7, 2002. (CX 5). Taking into consideration the medical evidence of record and consultation reports, Dr. Heidingsfelder opined that Mr. Kirby's coal dust exposure and smoking history combined to contribute to his death. He opined that "the disease patterns of COPD due to smoking and coal mine dust" are not always accurately separable. He based his opinion on the results of his autopsy examination, microscopic examination and the medical evidence of record. Dr. Heidingsfelder is board-certified in Anatomic and Clinical Pathology as well as Forensic Pathology. (CX 5). Currently, he serves as an Associate Pathologist for Pathology Services, Inc., as a Deputy Coroner, Clinical Associate Professor of Pathology at the Indiana University Medical Center, as well as maintaining his own private pathology practice. He is a member of the American Society of Clinical Pathologists, the College of American Pathologists and the American Academy of Forensic Sciences.

Richard L. Naeye, M.D., issued an independent medical review on October 28, 1999 and a supplemental report on July 19, 2002. (DX 18, EX 10). In authoring his initial review, Dr. Naeye considered the autopsy report, the autopsy slides, the Death

Certificate, hospital records and medical evidence that were contained in the record of Mr. Kirby's living miner claim. Dr. Naeye also considered accurate work and smoking histories. Regarding the autopsy slides, Dr. Naeye found "one to four anthracotic deposits in most pieces of lung tissue." (DX 18). He stated that "centrilobular emphysema is everywhere . . . so very severe that focal emphysema could never be detected." He found one anthracotic micronodule among the samples. Dr. Naeye opined that Mr. Kirby suffered from very mild simple coal workers' pneumoconiosis. He based this diagnosis on the findings from the autopsy slides. Finding the simple pneumoconiosis to be too mild to have impaired Mr. Kirby's lung function or contributed to his death, Dr. Naeye opined that Mr. Kirby's smoking history was to blame for his severe emphysema and bronchitis. Dr. Naeye is board-certified in Anatomic and Clinical Pathology. He is the Professor of Pathology and the Chairman of the Department of Pathology at the Pennsylvania State College of Medicine. He maintains membership in the International Academy of Pathology, the American Association of Pathologists, the American Society of Clinical Pathologists and the College of American Pathologists. Dr. Naeye has published numerous professional articles regarding issues of pregnancy, pediatric and perinatal pathology as well as occupational lung diseases among coal miners.

P. Raphael Caffrey, M.D., issued an independent medical review on November 10, 1999 and a supplemental report on July 29, 2002. (DX 18, EX 17). Taking into consideration accurate work and smoking histories, Dr. Caffrey also considered the autopsy report and slides, x-ray interpretations, medical record, pulmonary testing, and consultative reports. Regarding the autopsy slides, Dr. Caffrey found four macules and one micronodule, severe emphysema and acute bronchitis. (DX 18). He diagnosed Mr. Kirby with pneumonia, severe centrilobular and panlobular emphysema, chronic bronchitis, mild simple coal workers' pneumoconiosis, and anthracotic pigment in the lymph nodes. Dr. Caffrey opined that Mr. Kirby's pneumoconiosis was "too mild to cause any pulmonary disability" or to contribute to or hasten Mr. Kirby's death as it affected only five percent (5%) of the lung tissue. (EX 11). He attributed Mr. Kirby's emphysema and bronchitis solely to smoking. Dr. Caffrey is board-certified in Anatomic and Clinical Pathology. He is a member of the College of American Pathologists, the American Society of Clinical Pathologists, and the International Academy of Pathologists.

Peter G. Tuteur, M.D., issued an independent medical review on January 17, 1995 and supplemental reports on September 6, 2000 and July 30, 2002. (EX 3, 14, 17). Dr. Tuteur's initial opinion was

issued prior to Mr. Kirby's death. Taking into consideration the medical evidence of record and accurate work and smoking histories, Dr. Tuteur opined that Mr. Kirby did not have clinically, physiologically or radiographically significant pneumoconiosis. He diagnosed Mr. Kirby with emphysema and chronic bronchitis due solely to his smoking history. In his latter reports, Dr. Tuteur considered the autopsy report, Death Certificate, the medical evidence of record and consultative reports of other physicians. Dr. Tuteur opined that although the autopsy showed the presence of pneumoconiosis it "did not aggravate his health status, it did not contribute to cause or hasten his death." (EX 3). Dr. Tuteur concluded that Mr. Kirby's smoking history was the cause of his emphysema and chronic bronchitis which were

> responsible for his clinical symptomatology, his physical examination findings, the advanced impairment of pulmonary function, the changes seen on radiograph and the impaired health status characterized in part by severe breathlessness and in part by recurrent poorly controlled pulmonary infections that caused his death and hastened the time of his death.

(EX 3). Dr. Tuteur is board-certified in Internal Medicine and Pulmonary Disease. (EX 3). He has had additional training in the area of pulmonary medicine and is an Associate Professor of Medicine at Washington University in St. Louis, Missouri, where he is also the Director of the Pulmonary Function Laboratory. He maintains membership in the American College of Chest Physicians, the American College of Occupational Medicine, the American Thoracic Society, and the American Society of Internal Medicine. Regarding professional publications, Dr. Tuteur has authored numerous articles on pulmonary function and diseases.

Joseph J. Renn, III, M.D., submitted an independent medical review on September 27, 2000 and supplemental reports on July 23, 2002 and September 10, 2002. (EX 4, 12, 24). Taking into consideration accurate work and smoking histories, Dr. Renn also reviewed the medical records and consultative reports of record. He diagnosed Mr. Kirby with streptococcal pneumonia, chronic bronchitis, pulmonary emphysema, incidental adenocarcinoma, mild simple coal workers' pneumoconiosis, and an asthmatic component of chronic bronchitis. (EX 4). Dr. Renn opined that Mr. Kirby's chronic bronchitis and emphysema were due solely to his past smoking. He concluded that Mr. Kirby's mild pneumoconiosis was "pathologically detectable but was not clinically, physiologically, or radiographically detectable. As such, it could not have

contributed to his demise." (EX 4). Dr. Renn is board-certified in Internal Medicine and Pulmonary Disease. He is a Clinical Associate at the West Virginia University School of Medicine and engages in consulting work for the Monongalia County Chest Diagnostic Center and the U. S. Industrial Medicine Corporation. He is a member of the American College of Chest Physicians, the American Thoracic Society and the American College of Physicians.

Gregory J. Fino, M.D., issued an independent medical review on September 28, 2000 and supplemental reports on August 5, 2002 and September 6, 2002. (EX 5, 16, 23). Dr. Fino considered accurate work and smoking histories as well as the medical records and consultative reports of record in his opinion. Dr. Fino opined that "the medical information that is present in this case does not support a clinically significant contribution to this man's death from coal mine dust inhalation." (EX 23). Finding the extent of pneumoconiosis to be too mild to contribute to significant COPD, Dr. Fino concluded that Mr. Kirby's fifty-year smoking history was the cause of Mr. Kirby's obstructive pulmonary disease. Dr. Fino is board-certified in Internal Medicine and Pulmonary Disease. He received additional training in pulmonary medicine and has published several articles in professional medical journals, predominantly addressing CREST syndrome.[2]

Abdul K. Dahhan, M.D., submitted an independent medical review on March 21, 2002 and a supplemental report on July 29, 2002. (EX 8, 13). Dr. Dahhan considered the medical evidence and consultative reports of record in reaching his conclusions. He diagnosed Mr. Kirby with mild simple coal workers' pneumoconiosis, chronic bronchitis and emphysema in addition to the pneumonia which was the primary cause of Mr. Kirby's death. (EX 8). Dr. Dahhan opined that Mr. Kirby's chronic bronchitis and emphysema were not caused by coal dust exposure as "[h]e terminated his exposure in 1992, a duration of absence sufficient to cause cessation of any industrial bronchitis he may have had." (EX 8). In his supplemental report, Dr. Dahhan noted that Mr. Kirby's simple pneumoconiosis was insufficient to cause cor pulmonale. Dr. Dahhan is board-certified in Internal Medicine and Pulmonary Medicine and received additional pulmonary medical training. He is a member of the American College of Chest Physicians and the American Thoracic Society.

[2] CREST Syndrome is a syndrome suffered by those with scleroderma, a chronic autoimmune disease.

Lawrence H. Repsher, M.D., submitted an independent medical review on May 7, 2002 and a supplemental report on July 30, 2002. (EX 9, 15). Dr. Repsher considered accurate work and smoking histories in addition to the medical evidence and consultative reports of record in making his conclusions. Dr. Repsher diagnosed Mr. Kirby with very mild coal workers' pneumoconiosis. The bases for this diagnosis included the absence of radiographic evidence of pneumoconiosis and lack of evidence of pneumoconiosis in the results of the various pulmonary function and arterial blood gas studies performed. (EX 9). Dr. Repsher opined that mild pneumoconiosis would not "cause[] or increase[] the risk of one developing bacterial pneumonia" and therefore did not hasten Mr. Kirby's death. (EX 9). In addition, Dr. Repsher concluded that Mr. Kirby's smoking was "more than adequate to account for all of his measurable obstructive disease and cor pulmonale." (EX 15). Dr. Repsher is board-certified in Internal Medicine and Pulmonary Disease and has received additional training in pulmonary medicine. He is the author of many professional articles, many of which address COPD, bronchial asthma and the effects of bronchodilators.

Everett F. Oesterling, M.D., issued an independent medical review on August 23, 2002. (EX 19). Dr. Oesterling reviewed autopsy slides and the medical evidence of record. Dr. Oesterling diagnosed Mr. Kirby with COPD, adenocarcinoma, significant acute and chronic small airway disease resulting in bronchopneumonia, and simple coal workers' pneumoconiosis. He opined that the "structural change due to mine dust exposure is insufficient to have altered pulmonary function and therefore could not have contributed to any lifetime disability. Moreover, they are insufficient to have contributed to, hastened or caused this gentleman's death." (EX 19). In addition, Dr. Oesterling concluded that cor pulmonale in this case was a result of pulmonary hypertension due to emphysema and not a result of coal dust exposure. Dr. Oesterling is board-certified in Anatomical and Clinical Pathology as well as Nuclear Medicine. He is the Chairman of Pathology at Ohio Valley General Hospital in McKees Rocks, Pennsylvania. He maintains membership in the American Society of Clinical Pathologists.

Francis H. Y. Green, M.D., issued an independent medical review on February 26, 2002. (CX 1). Dr. Green considered accurate work and smoking histories. Based on the medical evidence of record and his review of the autopsy slides, Dr. Green diagnosed Mr. Kirby with emphysema, chronic bronchitis, coal workers' pneumoconiosis, necrotizing bronchopneumonia and pulmonary vascular changes consistent with cor pulmonale. Dr. Green opined that the pneumoconiosis was of moderate severity due to the presence of coal

dust micronodules, coal dust macules in the lung tissue and "remnants of coal dust macules" present in most of the sections of the lung, which had been "destroyed by the emphysema." (CX 1). Dr. Green concluded that pneumoconiosis did contribute to Mr. Kirby's death as both cigarette smoking and coal mine dust exposure were the cause of his chronic bronchitis and emphysema. These conditions impaired Mr. Kirby's ability to fight pneumonia and pneumoconiosis contributed to pulmonary hypertension and cor pulmonale. Dr. Green is board-certified in Anatomic Pathology. Currently he serves as a Professor in the Department of Pathology at the University of Calgary and as Chair of the Respiratory Research Group. He also served as Chief of the Pathology Section for NIOSH from 1977 to 1985 where he administered the National Coal Workers Autopsy Study. He is a member of the International Academy of Pathology, the Canadian Association of Pathologists; and the Pathological Society of Great Britain and Northern Ireland. Dr. Green has written numerous articles and book chapters regarding issues in occupational lung disease. Many of these articles focused on lung diseases in coal miners and the research he has done in this field. In addition, Dr. Green is the author of the textbook Pathology of Occupational Lung Disease.[3]

Robert A. C. Cohen, M.D., submitted an independent medical review on August 7, 2002. (CX 2). In addition to accurate work and smoking histories, Dr. Cohen considered the medical evidence and consultative reports of record in his analysis. Dr. Cohen opined that Mr. Kirby's obstructive lung disease was a result of both his smoking history and coal dust exposure. He found that coal dust exposure and smoking contributed to Mr. Kirby's emphysema and chronic bronchitis and that these conditions denied him the "pulmonary reserve to withstand the effects of the pulmonary infection" which was the primary cause of death. (CX 2). Dr. Cohen is Board Certified in Internal Medicine with two sub-specialties in Pulmonary Disease and Critical Care. Dr. Cohen's Curriculum Vitae reveals extensive training and experience in pulmonary medicine. His current appointments include Senior Attending Physician in the Division of Pulmonary Medicine and Critical Care, Director of the Black Lung Clinics Program, and Director of the Pulmonary Function and Cardiopulmonary Exercise Laboratory, all at Cook County Hospital. He is also a Medical Advisor to the National Coalition of Black Lung and Respiratory Disease Clinics and a Consultant to the Department of Health and Human Services Black Lung Clinics Program. He is a fellow of the

[3] A. CHURG & FRANCIS H.Y. GREEN, PATHOLOGY OF OCCUPATIONAL LUNG DISEASE (2d ed. 1998).

American College of Chest Physicians and a member of the American Thoracic Society, the Society of Critical Care Medicine and the Society for Occupational and Environmental Health. Furthermore, he has authored and co-authored professional articles regarding pulmonary disease, particularly tuberculosis.

David L. Hinkamp, M.D., issued an independent medical review on August 2, 2002. (CX 3). Dr. Hinkamp considered accurate work and smoking histories, as well as the medical evidence and consultative opinions of record. He concluded that Mr. Kirby's emphysema and chronic bronchitis result from both smoking and coal dust exposure. Dr. Hinkamp reasoned that Mr. Kirby had "substantial exposure" to cigarette smoking and coal dust and that "those agents combined to cause his severe COPD which was the primary contributing factor to the development of pneumonia and to his inability to survive the pneumonia." (CX 3). Dr. Hinkamp is board-certified in Preventative Medicine and Occupational Medicine. He is the Director of Occupational/Environmental Medicine at Central Occupational Health Organization in Chicago, Illinois. In addition to membership in the American Academy of Occupational Medicine and the Association of Occupational and Environmental Clinics, Dr. Hinkamp has written published professional articles involving the effects of hazardous exposure.

Perry Guariglia, M.D., issued an independent medical review on August 7, 2002. (CX 4). After reviewing the autopsy slides, the medical evidence and consultative opinions of record, Dr. Guariglia diagnosed Mr. Kirby with necrotizing pneumonia, pneumoconiosis, emphysema, chronic bronchitis, pulmonary hypertension, fibrosis and pleuritis. He also considered accurate work and smoking histories. Regarding the autopsy slides, Dr. Guariglia found that "virtually all sections" of the lung showed dust macules "adjacent to, or within, areas of emphysema." (CX 4). He opined that Mr. Kirby's death was primarily caused by pneumonia, but secondarily caused by "severe emphysema and chronic bronchitis due to a synergistic combination of coal workers' pneumoconiosis and the given history of cigarette smoking." (CX 4). Dr. Guariglia is board-certified in Anatomic and Clinical Pathology. He is an Associate Professor of Pathology at Rush Medical College in Chicago, Illinois. In addition, he maintains membership in the American Society of Clinical Pathologists and the College of American Pathologists.

Steven M. Koenig, M.D., submitted an independent medical review on November 9, 2002. (CX 6). Taking into consideration accurate work and smoking histories, Dr. Koenig also reviewed the medical evidence and consultative reports of record. Dr. Koenig opined that coal dust exposure contributed to Mr. Kirby's COPD. He

noted that the pulmonary function studies administered after Mr. Kirby quit smoking did not show the expected return to normal levels of decline in FEV_1. As Mr. Kirby was still working in the mines until 1992, Dr. Koenig attributed the "accelerated deterioration" in FEV_1 levels to coal dust exposure. He believed that Mr. Kirby's coal dust exposure was of "sufficient intensity and duration to cause respiratory impairment in a susceptible individual." Dr. Koenig is board-certified in Internal Medicine, Pulmonary Disease, and Critical Care. He received additional training in pulmonary disease and critical care. In addition to serving as an Associate Professor of Medicine at the University of Virginia School of Medicine, he is the Director of the Occupational Lung Disease Program, Director of the Bronchoscopy Suite, and Director of the Pulmonary Rehabilitation Program all at the University of Virginia. He has written numerous articles for publication on pulmonary and critical care issues.

Deposition Testimony

Dr. Tuteur was deposed on September 24, 2002. (EX 21). He affirmed the opinions in his January 17, 1995, September 6, 2000 and July 30, 2002 medical reviews. He reiterated that Mr. Kirby suffered from mild pneumoconiosis and added that his condition fell within the definitions of legal as well as clinical pneumoconiosis. He stated that although coal mine dust "is a possible etiologic agent in the development of air flow obstruction," he believed that "coal mine induced COPD of clinical significance is very, very infrequent." (EX 21 at 11-12). In addition, Dr. Tuteur opined that there was evidence of cor pulmonale, but that emphysema was the cause and that coal dust exposure did not contribute to the emphysema.

Dr. Renn was deposed on October 19, 2000. (EX 6). He affirmed his earlier opinions and his conclusion that Mr. Kirby's death was due to his smoking history. He opined

> the degree of coal workers' pneumoconiosis that he had pathologically was too mild to have caused him ventilatory impairment to the extent that he would have been susceptible to death from it . . . so mild that it would not have resulted in any predisposition to develop that infection. It would not have resulted in any predisposition to any severe destruction of the pulmonary parenchymal architecture and anatomy such that it would have predisposed him to pneumonia.

(EX 6 at 23-24). Moreover, he stated that coal dust exposure did not contribute to Mr. Kirby's emphysema. In support of this proposition, Dr. Renn noted the results of the pulmonary function tests were typical of smoke-induced obstructive disease and that the type of emphysema suffered by Mr. Kirby was not focal emphysema, which he opined is the type caused by coal dust. (EX 6 at 26-29). Mr. Kirby's symptomatology, such as barreled chest, wheezes, rhonchi, and test results showed a disease consistent with smoking-induced diseases. (EX 6 at 33-34).

Dr. Fino was deposed on November 10, 2000. (EX 7). He opined that objective evidence showed that Mr. Kirby's obstructive lung diseases were not caused by pneumoconiosis. As Mr. Kirby's pneumoconiosis was diagnosable only at autopsy, Dr. Fino stated that he could not have had a "significant or severe or disabling or death-causing obstruction due to pneumoconiosis." (EX 7 at 11-12). In addition, Dr. Fino opined that the reversibility shown with administration of bronchodilators in the pulmonary function studies showed that his pulmonary impairment was not coal dust exposure related as "coal dust related conditions are not reversible." (EX 7 at 14).

Dr. Repsher was deposed on September 12, 2002 and affirmed his medical reviews of May 7, 2002 and July 30, 2002. (EX 20). He opined that coal dust exposure can result in focal emphysema but not panlobular emphysema. As Mr. Kirby suffered from panlobular emphysema, he concluded it could not have resulted from coal dust exposure. (EX 20 at 8-9). Although Mr. Kirby did show evidence of focal emphysema as well, Dr. Repsher stated that it was such a small amount that "it would not cause any measurable . . . effect on diffusing capacity or any other lung function tests." (EX 20 at 11). Regarding Mr. Kirby's chronic bronchitis, Dr. Repsher found that while coal dust might have exacerbated his bronchitis "it would have been aggravated to such a small degree that the amount of that aggravation would not be individually measurable." (EX 20 at 11).

Dr. Green was deposed on November 1, 2002. (CX 15). He affirmed his February 26, 2002 medical review. Dr. Green stated that coal mine dust contributed to Mr. Kirby's pulmonary impairment by causing pneumoconiosis and "by contributing to the chronic bronchitis and emphysema." (CX 7 at 15). He added that pneumoconiosis and the obstructive impairments would put stress on the heart causing cor pulmonale. Regarding emphysema, Dr. Green opined that coal mine dust while "primarily associated with focal

and centriacinar[4] emphysema," it can also cause panacinar or panlobular emphysema. (CX 7 at 19). His own research and studies have shown a significant increase of panlobular emphysema in coal miners as compared to other groups. (CX 7 at 30). Dr. Green disagreed with the notion that cessation of exposure to coal dust would eliminate industrial bronchitis. He stated that changes in the airways may be permanent or take many years to reverse. (CX 7 at 33). In addition, Dr. Green explained his opinion that Mr. Kirby's pneumoconiosis was moderately severe in conflict with the other physicians of record. He has found that the presence of emphysema interferes with the reading of chest x-rays and that the destruction of lung tissue by emphysema breaks up pneumoconiosis lesions therefore making it "quite difficult to recognize the classic lesions of pneumoconiosis against a background of very severe emphysema." (CX 7 at 34-35).

DISCUSSION AND APPLICABLE LAW

Because Mrs. Kirby filed her application for survivor's benefits after March 31, 1980, this claim shall be adjudicated under the regulations at 20 C.F.R. Part 718. To establish entitlement to benefits under this part of the regulations, Claimant must prove by a preponderance of the evidence that the miner had pneumoconiosis, that his pneumoconiosis arose from coal mine employment, and that his death was due to pneumoconiosis. *Peabody Coal Co. v. Director, OWCP,* 972 F.2d 178 (7th Cir. 1992).

On August 7, 1996, Mr. Kirby was awarded Black Lung benefits in a Decision and Order adjudicating his living miner's claim. (DX 1). The administrative law judge determined that Mr. Kirby had proven by a preponderance that he had pneumoconiosis arising out of coal mine employment and that he was totally disabled due to that condition. Claimant argues that issue preclusion applies in this case to prohibit Employer from re-litigating the existence of pneumoconiosis in this case. Claimant addresses the recent Seventh Federal Circuit decision in *Zeigler Coal Co. v. Director, OWCP* [*Villain*], 312 F.3d 332 (2002), which involved this issue. Although *Villain* permits an exception to issue preclusion when autopsy evidence is offered, Claimant contends that this exception is unavailable to Employer as it has not offered the autopsy results to show that pneumoconiosis was found in error in the previous Decision and Order. Employer argues that the exception applies whenever autopsy evidence is offered in a survivor claim.

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[4] The term centriacinar is interchangeable with centrilobular. (CX 7).

In *Villain*, the Seventh Circuit held that the autopsy exception to issue preclusion allows "[b]oth a mine operator and a survivor . . . to introduce autopsy evidence in an effort to show that the determination made during the miner's life was incorrect." *Villain*, 312 F.3d at 334. The court further explained that

> there is no point in readjudicating the question whether a given miner had pneumoconiosis unless it is possible to adduce highly reliable evidence – which as a practical matter means autopsy results. Otherwise the possibility that the initial decision was incorrect is no reason to disturb it. We therefore hold that a grant of survivor's benefits may rest on findings made during the miner's life.

Villain, 312 F.3d at 334 (citation omitted).

Employer has not alleged that the prior Decision and Order held incorrectly that Mr. Kirby had clinical pneumoconiosis. Therefore, Employer should not be permitted to readjudicate the issue of the existence of pneumoconiosis. Furthermore, the autopsy results indicate that the prior Decision and Order was correct in finding the existence of pneumoconiosis. However, Employer argues that while the autopsy evidence establishes the presence of clinical pneumoconiosis, it does not establish the presence of legal pneumoconiosis. To address Employer's argument, I will analyze the existence of legal pneumoconiosis in accordance with the regulations.

Pneumoconiosis and Causation

Under the Act, "'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b). The regulations provide that this definition encompasses both "clinical" and "legal" pneumoconiosis. 20 C.F.R. § 718.201(a). Clinical pneumoconiosis is defined as those diseases recognized by the medical community as pneumoconiosis, *i.e.* the conditions characterized by the permanent deposition of a substantial amount of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. 20 C.F.R. § 718.201(a)(1). Legal pneumoconiosis is defined as "any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic

restrictive or obstructive pulmonary disease arising out of coal mine employment." 20 C.F.R. § 718.201(a)(2).

In this case, Employer has conceded that Mr. Kirby suffered from medical or clinical pneumoconiosis. (Tr. 14). Employer maintains that Mr. Kirby did not suffer from legal pneumoconiosis. (Tr. 14). Specifically, Employer argues that Mr. Kirby's emphysema and chronic bronchitis did not arise out of coal mine employment. Therefore, despite Employer's concession of the presence of pneumoconiosis, I will analyze the evidence to determine whether Mr. Kirby suffered from legal pneumoconiosis.

Section 718.202(a) provides four methods for determining the existence of pneumoconiosis. Under Section 718.202(a)(1), a finding of pneumoconiosis may be based upon x-ray evidence. In evaluating the x-ray evidence, I assign heightened weight to interpretations of physicians who qualify as either a board-certified radiologist or "B" reader. *See Dixon v. North Camp Coal Co.*, 8 BLR 1-344, 1-345 (1985). I assign greatest weight to interpretations of physicians with both of these qualifications. *See Woodward v. Director, OWCP*, 991 F.2d 314, 316 n.4 (6th Cir. 1993); *Sheckler v. Clinchfield Coal Co.*, 7 BLR 1-128, 1-131 (1984).

The evidence of record contains thirty-one interpretations of five chest x-rays. Of these interpretations, twenty-three were negative for pneumoconiosis, two were positive, two x-rays were determined to be unreadable, and four x-ray interpretations did not address the presence of pneumoconiosis. All of the negative interpretations were read by B-readers and fourteen of the negative interpretations were read by dually qualified physicians. Both of the positive interpretations were read by a B-reader. Because the negative readings constitute the majority of interpretations and are verified by more, highly-qualified physicians, I find that the x-ray evidence fails to support a finding of pneumoconiosis.

Under Section 718.202(a)(2), a claimant may establish pneumoconiosis through autopsy evidence. The autopsy evidence of record establishes that Mr. Kirby had clinical pneumoconiosis. Therefore, the evidence supports a finding of clinical pneumoconiosis under Section 718.202(a)(2).

Under Section 718.202(a)(3), a claimant may prove the existence of pneumoconiosis if one of the presumptions at Sections 718.304 to 718.306 applies. Section 718.304 requires x-ray, biopsy, or equivalent evidence of complicated pneumoconiosis. Because the record contains no such evidence, this presumption is

unavailable. The presumptions at Sections 718.305 and 718.306 are inapplicable because they only apply to claims that were filed before January 1, 1982, and June 30, 1982, respectively. Because none of the above presumptions apply to this claim, Claimant has not established pneumoconiosis pursuant to Section 718.202(a)(3).

Section 718.202(a)(4) provides that a claimant may establish the presence of pneumoconiosis through a reasoned medical opinion. Although the x-ray evidence does not establish pneumoconiosis, a physician's reasoned opinion nevertheless may support the presence of the disease if it is explained by adequate rationale besides a positive x-ray interpretation. *See Trumbo v. Reading Anthracite Co.*, 17 BLR 1-85, 1-89 (1993); *Taylor v. Director, OWCP*, 1-22, 1-24 (1986).

Although each physician of record opines that Mr. Kirby suffered from clinical pneumoconiosis, there is disagreement among them regarding the etiology of his emphysema and chronic bronchitis or COPD.

Drs. Naeye, Caffrey, Tuteur, Renn, Fino, Dahhan, Repsher and Oesterling opined that Mr. Kirby's emphysema and chronic bronchitis were not caused by coal dust exposure.

Dr. Naeye reviewed the autopsy slides and the medical evidence and consultative reports of record. Although he found that Mr. Kirby suffered from clinical pneumoconiosis, he concluded that the emphysema and chronic bronchitis were solely due to cigarette smoking. Dr. Naeye stated that his review of the studies relevant to this issue indicated that "mine dust has no role or only an insignificant role in the genesis of centrilobular emphysema...in US miners of bituminous coal." (DX 18). This conflicts with the studies accepted by the Department of Labor that have found that coal dust exposure can lead to the development of centrilobular emphysema. 65 Fed. Reg. 79941-79942 (Dec. 20, 2000). Therefore, I find his opinion to be not well reasoned and I accord it less weight.

Dr. Caffrey reviewed the autopsy slides and the medical evidence and consultative reports of record. He opined that the "minimal amount of [pneumoconiosis] would not have caused any disabling emphysema or chronic bronchitis." (EX 11). In addition, he stated that the emphysema and chronic bronchitis were attributable to Mr. Kirby's smoking history. Dr. Caffrey did not opine that coal dust exposure made no contribution to Mr. Kirby's emphysema or chronic bronchitis, but that it "would not have by itself have caused him [sic] pulmonary disability." (CX 11). An

equivocal or vague opinion may be given less weight. *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995). I find Dr. Caffrey's opinion to be vague and therefore also entitled to less weight.

Dr. Tuteur reviewed the medical evidence and consultative reports of record in his medical reviews. In his deposition, Dr. Tuteur stated that Mr. Kirby's emphysema was smoking-induced. He reasoned that "mild coal workers' pneumoconiosis itself doesn't produce emphysema. That's limited to in the classic form of progressive massive fibrosis, and when I say emphysema, I mean panlobular and centrilobular emphysema." (EX 21 at 23). As with Dr. Naeye, this reasoning diverges from that which the Department of Labor has accepted. Those accepted studies have found that simple pneumoconiosis can cause centrilobular emphysema. 65 Fed. Reg. 79941-79942 (Dec. 20, 2000). Therefore, I find Dr. Tuteur's opinion to be poorly reasoned and entitled to less weight.

Dr. Renn reviewed the medical evidence and consultative reports of record. Dr. Renn also opined that Mr. Kirby's emphysema and chronic bronchitis were smoking-induced. He stated that coal mine dust causes focal emphysema and not centrilobular or panlobular emphysema. (EX 6 at 29-31). In addition, Dr. Renn concluded that even if coal dust exposure had caused him to suffer industrial bronchitis that it would have disappeared within six months of cessation of exposure. (EX 6 at 31). He stated that as Mr. Kirby's bronchitis continued for years after his retirement from mining, it could not have been caused by coal dust exposure. As above, Dr. Renn's views on the potential causes of centrilobular emphysema are at odds with the Department of Labor's accepted studies. Likewise, Dr. Renn's views on industrial bronchitis diverge with that of the Department of Labor. 65 Fed. Reg. 79939-41, 79969-72 (Dec. 20, 2000). Therefore, I find Dr. Renn's opinion to be poorly reasoned and I assign it less weight.

Dr. Fino opined that it is possible for pneumoconiosis to cause a breathing impairment even though the pneumoconiosis is undetectable on an x-ray. However, he also stated that Mr. Kirby's breathing impairment was not caused by pneumoconiosis as "his pneumoconiosis was only diagnosable at autopsy" and so therefore could not have caused significant obstruction. I find this reasoning to be equivocal and assign his opinion diminished weight since his opinion in that regard is not explained. In addition, he reviewed and criticized various studies that analyzed coal dust exposure and obstructive lung disease. He discredited the majority of the studies due to "selection bias" and that many of the studies were done "prior to the institution of dust regulations." (EX 14). The Department of Labor disagreed with Dr. Fino when it addressed

many of these studies and Dr. Fino's viewpoint in the December 20, 2000 Amendments to Act. 65 Fed. Reg. 79939-79942 (2000). Therefore, as the foundations of Dr. Fino's opinion diverge from what the Department of Labor has found acceptable, Dr. Fino's opinion I find to be not well reasoned and I assign it less weight.

Dr. Dahhan opined that Mr. Kirby's chronic bronchitis and emphysema were not due to coal dust exposure as his exposure ended with his 1992 retirement from coal mining, which was "a duration of absence sufficient to cause cessation of any industrial bronchitis he may have had." (EX 8). In addition, Dr. Dahhan noted that Mr. Kirby did not suffer from focal emphysema for the proposition that his centrilobular and panlobular emphysema could not have been caused by coal dust inhalation. These views are divergent from those accepted by the Department of Labor. Therefore, I find Dr. Dahhan's opinion to be poorly reasoned and entitled to less weight.

Dr. Repsher also opined that coal dust exposure causes only focal emphysema and not centrilobular or panlobular. As this view is at odds with the studies accepted by the Department of Labor, I find Dr. Repsher's opinion to be poorly reasoned and entitled to less weight.

After reviewing the autopsy slides and the medical evidence of record, Dr. Oesterling opined that neither Mr. Kirby's emphysema nor chronic bronchitis were caused, even in part, by coal dust exposure. He stated that any bronchitis Mr. Kirby would have suffered from coal dust exposure would have subsided after his retirement. (EX 19). He also notes that panlobular emphysema could not be caused by coal dust exposure. Although Dr. Oesterling reports the presence of centrilobular emphysema in the lung tissue represented in the autopsy slides, he attributes its cause solely to cigarette smoking without considering the effects of coal dust exposure. I find Dr. Oesterling's opinion to be poorly reasoned and divergent from the studies accepted by the Department of Labor. Therefore, I assign it less weight.

Drs. Heidingsfelder, Green, Cohen, Hinkamp, Guariglia and Koenig opined that Mr. Kirby's emphysema and chronic bronchitis resulted, in part, from coal dust exposure.

Dr. Heidingsfelder performed the autopsy and the microscopic examination thereafter; however, an autopsy prosector's opinion is not entitled to more weight than the opinion of a reviewing pathologist. *Peabody Coal Co. v. McCandless*, 255 F.3d 465 (7th Cir. 2001). In finding that Mr. Kirby's COPD arose out of a combination of coal dust exposure and cigarette smoking, Dr. Heidingsfelder

opined that the effects of those exposures are not always separable. I interpret his statement to mean that either of these maladies could have independently caused the COPD but that it is difficult to distinguish the extent of the separate contributions. I find this opinion to be well documented and reasoned and I assign it full weight.

Dr. Green examined the autopsy slides and the medical evidence of record. Dr. Green concluded that Mr. Kirby's smoking and coal dust exposure both contributed to his emphysema and chronic bronchitis. This conclusion was based on his findings on the autopsy slides, his review of the medical evidence of record and the results of research and studies performed by him and other experts in occupational lung diseases. I find his opinion to be well documented and reasoned. Dr. Green has devoted his professional career to occupational lung disease, with emphasis on pneumoconiosis suffered by coal miners. He is the author of a textbook on occupational lung disease as well as numerous articles addressing pneumoconiosis from 1979 until the present. Several of Dr. Green's studies have been accepted by the Department of Labor. 65 Fed. Reg. 79939-79942 (2000). I find that Dr. Green's well-documented and reasoned opinion together with his superior credentials entitle his opinion to great weight.

Dr. Cohen reviewed the medical evidence and consultative reports of record in reaching his conclusions. Citing to several published studies, he opined that based on the medical evidence and Mr. Kirby's work and smoking histories that his emphysema and chronic bronchitis were caused by both coal dust exposure and cigarette smoking. I find his report to be well documented and reasoned. In addition, Dr. Cohen has substantial experience in pulmonary medicine, as shown by his current positions and appointments in the pulmonary medicine field and focus on coal workers' pneumoconiosis. Therefore, I assign his opinion more weight.

After reviewing the medical evidence and consultative reports of record, Dr. Hinkamp opined that Mr. Kirby's "severe emphysema and chronic bronchitis resulted from both occupational coal dust exposure and tobacco abuse." (CX 3). Dr. Hinkamp considered the amount of exposure to both coal dust and cigarette smoking, the amount of pneumoconiosis in the lung, work history and medical records in arriving at a diagnosis. I find his opinion to be well documented and reasoned regarding pneumoconiosis and causation and I assign it full weight.

Dr. Guariglia reviewed the autopsy slides and the medical evidence of record and concluded that Mr. Kirby's emphysema and chronic bronchitis were caused by the combination of coal dust exposure and cigarette smoking. He stated that the "pathogenic synergy of these two entities is well documented in the literature." (CX 4). However, Dr. Guariglia did not reference the "literature" supporting his assertion or explain the how the findings in his examination of the slides allowed him to arrive at his conclusion. Therefore, although it would tend to support the opinions of some of the other physicians, I assign less weight to his opinion.

Dr. Koenig opined that coal dust exposure contributed to Mr. Kirby's emphysema and bronchitis. In support of this assertion, Dr. Koenig offered the medical evidence of record, work and smoking histories, and cited studies that established this connection. I find Dr. Koenig's opinion to be well documented and reasoned and entitled to full weight.

Although the medical records of Drs. Combs and Gehlhausen report the diagnoses of emphysema and chronic bronchitis, they do not provide the bases for those diagnoses. Therefore, those records are entitled to less weight.

In sum, only the opinions of Drs. Cohen, Heidingsfelder, Hinkamp and Koenig are entitled to full weight and the opinion of Dr. Green is entitled to great weight due to his superior qualifications as an expert in the occupational lung disease field. The opinions of Drs. Naeye, Tuteur, Renn, Fino, Dahhan and Oesterling were discounted as the bases for their opinions were divergent from the position taken by the Department of Labor. Dr. Caffrey's opinion was discounted because of its vague conclusions. Dr. Guariglia's opinion received less weight as it was not well documented. Therefore, I find that the weight of the evidence of record supports a finding of legal pneumoconiosis under Section 718.202(a)(4) in that Mr. Kirby's emphysema and bronchitis were caused, in part, by coal dust exposure.

Causation of Pneumoconiosis

Once pneumoconiosis has been established, the burden is upon the Claimant to demonstrate by a preponderance of the evidence that the pneumoconiosis arose out of the miner's coal mine employment. 20 C.F.R. § 718.203(b) provides:

> If a miner who is suffering or has suffered from pneumoconiosis was employed for ten years or more in one

> or more coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of such employment.

I have found that Mr. Kirby was a coal miner for twenty years, and that he had pneumoconiosis. Claimant is entitled to the presumption that his pneumoconiosis arose out of his employment in the coal mines. Regarding clinical pneumoconiosis, all physicians of record opine that this condition arose out of coal mine employment. Employer concedes that Mr. Kirby's clinical pneumoconiosis arose out of coal mine employment. As discussed above, there is disagreement among the physician's of record as to whether Mr. Kirby's emphysema and chronic bronchitis arose out of his coal mine employment. As I have found that Mr. Kirby's emphysema and chronic bronchitis did arise out of coal mine employment, I find that Claimant's clinical and legal pneumoconiosis arose from his coal mine employment.

Death and Causation

Claimant is entitled to benefits as the Miner's survivor if she demonstrates that his death was due to pneumoconiosis. 30 U.S.C. § 901(a); 20 C.F.R. § 718.205(a). 20 C.F.R. § 718.205(c) provides that:

> For the purpose of adjudicating survivors' claims filed on or after January 1, 1982, death will be considered to be due to pneumoconiosis if any of the following criteria is met:
>
> 1. Where competent medical evidence established that the miner's death was due to pneumoconiosis, or
>
> 2. Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where the death was caused by complications of pneumoconiosis, or
>
> 3. Where the presumption set forth at §718.304 is applicable.
>
> 4. However, survivors are not eligible for benefits where the miner's death was caused by traumatic injury or a principal cause of death was a medical condition not related to pneumoconiosis, unless pneumoconiosis was a substantially contributing cause of death.

5. Pneumoconiosis is a “substantially contributing cause” of a miner’s death if it hastens the miner’s death.

The United States Court of Appeals for the Seventh Circuit, within whose jurisdiction the instant case arises, has held that pneumoconiosis will be considered a substantially contributing cause of the miner's death if it actually hastened the miner's death, even if only briefly. *Zeigler Coal Co. v. Director, OWCP [Villain],* 312 F.2d 332, 334 (7th Cir. 2002); *Peabody Coal Co. v. Director, OWCP [Railey]*, 972 F.2d 178, 16 BLR 2-121 (7th Cir. 1992). Claimant has the burden of demonstrating by a preponderance of the evidence that pneumoconiosis was a substantially contributing cause of the Miner’s death. The Supreme Court of the United States relates the term "preponderance of the evidence," to "the degree of proof which must be adduced by the proponent of a rule or order to carry its burden of persuasion in an administrative proceeding." See, *Steadman v. SEC*, 450 U.S. 91, 101 S.Ct. 999 (1981). If that degree is a preponderance, then the initial trier of fact must believe that it is more likely than not that the evidence establishes the proposition in question. *Id*.

The Death Certificate listed Sepsis-Strep, pneumonia and pneumoconiosis as the causes of Mr. Kirby’s death. Dr. Gehlhausen signed the Death Certificate. He had treated Mr. Kirby for respiratory infections and other ailments during hospital stays from April of 1996 until his final hospital admission in March of 1999. Therefore, Dr. Gehlhausen was familiar with Mr. Kirby’s condition. Although the Death Certificate was signed after the autopsy had been performed, it lacks explanation of how pneumoconiosis contributed to Mr. Kirby’s death. A Death Certificate stating that pneumoconiosis contributed to the miner’s death without further explanation is insufficient. *Bill Branch Coal Co. v. Sparks*, 213 F.3d 186 (4th Cir. 2000). Dr. Gehlhausen recorded in the notes of Mr. Kirby’s final hospital admission that he suffered from pneumoconiosis and reported that it acted secondarily to Mr. Kirby’s death. The notes do not reveal the basis for that diagnosis. The record contains no further explanation by Dr. Gehlhausen for his findings. As a result, I assign the Death Certificate less weight.

Some of the physicians of record opined that right-sided cor pulmonale played a role in Mr. Kirby’s death. There is disagreement among those physicians as to whether the cor pulmonale was attributable to pneumoconiosis. Dr. Green opined that pneumoconiosis contributed to cor pulmonale in Mr. Kirby’s case. (CX 2). He concluded that emphysema and chronic bronchitis, caused

in part by coal dust exposure, burdened the heart causing cor pulmonale. (CX 7 at 15). In addition, he stated that clinical pneumoconiosis contributed to cor pulmonale in this case by physically narrowing the arteries. (CX 7 at 43-44). Dr. Green reported evidence of cor pulmonale from the autopsy slides which showed that the right heart thickness was twice that of a normal heart. (CX 7 at 44).

Dr. Naeye also found evidence of cor pulmonale in his review of the autopsy slides. Dr. Naeye opined that cor pulmonale was a result of "a genetic predisposition to small pulmonary arteries to contract with low levels of oxygen in the surrounding tissues and chronic alveolar hyperventilation which in turn is the consequence of centrilobular emphysema." (DX 18).

Dr. Tuteur agreed that there was evidence of cor pulmonale. However, he reported that there was insufficient "severity and profusion of scar tissue to cause pulmonary hypertension that would cause cor pulmonale." (EX 21 at 31). He attributed the cor pulmonale to Mr. Kirby's centrilobular emphysema.

Dr. Dahhan found that Mr. Kirby's mild simple pneumoconiosis was insufficient to cause the development of cor pulmonale. Dr. Dahhan further opined that the medical data showed no evidence of cor pulmonale. He did find evidence of pulmonary hypertension, but did not offer the etiology of that condition.

Dr. Repsher opined that while pneumoconiosis can lead to cor pulmonale it is "quite uncommon and rarely seen with coal workers' pneumoconiosis." (EX 20 at 72). He attributed cor pulmonale to Mr. Kirby's smoking-induced obstructive diseases. (EX 15).

Dr. Oesterling determined that emphysema caused pulmonary hypertension which lead to cor pulmonale. He opined that as emphysema was the cause, cor pulmonale could not be attributed to coal dust exposure. (EX 19).

Dr. Caffrey did not opine as to the etiology of cor pulmonale. Drs. Heidingsfelder, Combs, Gehlhausen, Renn, Fino, Cohen, Guariglia, Hinkamp and Koenig did not address the presence or absence of cor pulmonale.

As discussed above, Dr. Green's opinion is well documented and reasoned and he possesses superior qualifications. I assign his opinion great weight. The remaining physicians who addressed the presence and etiology of Mr. Kirby's cor pulmonale based their reasoning on the notion that coal dust exposure cannot cause

centrilobular emphysema. As noted above, I find their opinions to be poorly reasoned and assign them less weight.

Each of the physicians who addressed the cause of Mr. Kirby's death opined that his emphysema and chronic bronchitis contributed to his death. Dr. Green opined that Mr. Kirby's clinical pneumoconiosis also contributed to his death. Although pneumonia was the primary cause of death, each physician found that these obstructive impairments hastened his death. As was stated, Dr. Green's well documented and reasoned opinion as well as his superior qualifications entitle his opinion to great weight. I have found that the medical evidence supports a finding that Mr. Kirby suffered from clinical and legal pneumoconiosis. Mr. Kirby's legal pneumoconiosis comprised the emphysema and chronic bronchitis. I have found that the medical evidence supports a finding that Mr. Kirby's emphysema and chronic bronchitis were caused by coal dust exposure during coal mine employment. As all the physicians of record addressing cause of death found that emphysema and chronic bronchitis contributed, I conclude that Mr. Kirby's death was hastened by his clinical and legal pneumoconiosis.

Employer's Liability to Mrs. Kirby's Survivors

Employer designated as an issue whether in the event of Mrs. Kirby's death prior to the final adjudication of the claim, Employer would be liable for payment of benefits to her estate, heirs or assigns. The record indicates that Mrs. Kirby is currently living. Therefore, I find this issue to be moot and will not address it.

ENTITLEMENT

In the case of a widow who has shown a miner's death was due to pneumoconiosis, benefits commence with the first day of the month in which the miner died. Based upon my review of the record, Claimant, Mildred M. Kirby is entitled to benefits commencing March 1, 1999. (DX 27)

ATTORNEY FEE

Claimant's counsel has fifteen days from the date of receipt of this decision to submit an application for an attorney's fee. The application must be served on all parties, including Claimant, and proof of service must be filed with the application. The parties are allowed fifteen days following service of the application to file objections to the fee application. If no

response is received within this fifteen day period, any objections to the requested fees will be deemed waived.

In preparing the attorney's fee application, the attention of counsel is directed to the provisions of Sections 725.365 and 725.366. According to these provisions and applicable case law, the fee application of Claimant's counsel shall include the following:

1. A complete statement of the extent and character of each separate service performed shown by date of performance;

2. An indication of the professional status (e.g., attorney, paralegal, law clerk, lay representative, or clerical) of the person performing each quantum of work and customary billing rate;

3. A statement showing the basis for the hourly rate being charged by each individual responsible for the rendering of services;

4. A statement as to the attorney or other lay representative's experience and expertise in the area of Black Lung law;

5. A listing of reasonable unreimbursed expenses, including travel expenses; and

6. A description of any fee requested, charged, or received for services rendered to the claimant before any state or federal court or agency in connection with a related matter.

Thomas E. Johnson, counsel for Claimant, will have twenty (20) days following the exhaustion of all appeals within which to file his attorney fee application.

ORDER

The Employer, Old Ben Coal Company, is ordered to pay the following:

1. To Claimant, all benefits to which she is entitled under the Act commencing March 1, 1999;

2. To Claimant, all medical and hospitalization benefits to which she is entitled commencing March 1, 1999, or otherwise provide for such service;

3. To the Secretary of Labor, reimbursement for any payments that the Secretary has made to Claimant under the Act. The Employer may deduct such amounts, as appropriate, from the amount that it is ordered to pay under paragraphs 1 and 2 above. 20 C.F.R. § 725.602

4. To Claimant or the Black Lung Disability Trust Fund, as appropriate, interest at the rate established by Section 6621 of the Internal Revenue Code of 1954. Interest is to accrue thirty days from the date of the initial determination of entitlement to benefits. 20 C.F.R. § 725.608.

A

RUDOLF L. JANSEN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington D.C. 20013-7601. A copy of this Notice of Appeal also must be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.